HIT Policy Committee
Quality Measures Workgroup
Transcript
July 17, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning everyone; my name is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I'll now take roll. David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Tripp Bradd?

Tripp Bradd – Skyline Family Practice, VA

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Tripp. Russ Branzell? Helen Burstin? Neil Calman? Timothy Ferris? Patrick Gordon? David Kendrick? Charles Kennedy? Karen Kmetik? Robert Kocher? Norma Lang? Marc Overhage? Laura Petersen? Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Eva. Sarah Scholle?

Sarah Scholle – National Committee for Quality Assurance

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Sarah. Cary Sennett? Jesse Singer? Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. Kalahn Taylor-Clark? James Walker?

Jim Walker – Chief Information Officer – Geisinger Health System

Here.

MacKenzie Robertson – Office of the National Coordinator

James, is that you James?

Jim Walker – Geisinger Health System – Chief Information Officer

Yes.

MacKenzie Robertson – Office of the National Coordinator

All right, thanks. Paul Wallace? Mark Weiner? Kate Goodrich? Daniel Green? Ahmed Calvo? Steven Solomon? Peter Lee? Marsha Lillie-Blanton? Jacob Reider? Jon White?

P. Jonathan White – Agency for Healthcare Research & Quality (AHRQ)

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jon. Westley Clark?

H. Westley Clark – Substance Abuse & Mental Health Services Administration

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Wes. Carolyn Clancy? Niall Brennan? Tony Trenkle? Michael Rapp? And is there any staff on the line?

Kevin Larsen – Office of the National Coordinator

Kevin Larsen from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kevin.

Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services

Patrice Holtz from CMS.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Patrice. Can everyone make sure they mute their computer speakers because we're getting some interference in the background? Any other staff on the line?

Maureen Boyles - Substance Abuse & Mental Health Services Administration

Maureen Boyles from SAMHSA.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Maureen. Okay, David, I'll turn it over to you.

David Lansky – Pacific Business Group on Health – President & CEO

Thanks, MacKenzie. This is David Lansky. Welcome everybody; thanks for joining, making time in midsummer. Where in kind of a funny moment as Kevin was just saying before we took the roll where we have a lot of lessons learned from the Stage 1 experience and the Stage 2 comment cycle and we have the Stage 2 rule not yet final in public and so some of the determinations made by CMS and ONC and the findings from the comment period are not fully available to us and we certainly want to build upon what's been learned and already decided in beginning our discussion about Stage 3. But we're a little bit handicapped to not having full access to the information that would probably help us make good decisions.

So, we're trying to sort out on this call our work plan going forward in the next few months now that we note that it may be until October that we have full access to the Stage 2 rule as kind of the foundation upon which to build, nonetheless, we need to proceed and get things moving for Stage 3.

There is an agenda that came out on this morning's e-mail that has a number of issues, important and complicated issues that we probably need to start thinking about as a group over the next several weeks. We have a series of meetings scheduled now so we have the opportunity to map out our work plan and we have immediately in front of us the August 1st Policy Committee meeting in case we want to bring anything to them for discussion.

I had hoped that we'd be able to start today and on the next meeting on the 30th get a first cut at some directional principles for where we think the quality measures should go for Stage 3 and I think that's still, even though we may not make the August 1st deadline, that still seems like a good idea that we, you know, take a deep breath, look at where we've come to, the status of the measure pipeline, the feedback we've had from the community and decide what kind of approach we want to take to Stage 3. So, I think in broad strokes that's what we want to do.

What we propose to do today was to take a brief look back to where we've come and what the progress has been on the measure development approach we recommended about a year ago and then take stock of what we heard from the hearing a month or so ago, and then do a little bit of work planning around where do we want to go from here in terms of any additional input or strategies to try to assess the direction going forward.

So, let me pause there and see if directionally that sounds right or if people have another perspective on it and I'd certainly welcome Paul's comments too since you're knee deep in Stage 3 already. But, Kevin or Paul in particular, anything that you want to add to that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I joined late, so I didn't hear the…something about October?

David Lansky – Pacific Business Group on Health – President & CEO

Oh, that was Kevin's estimate of when we could expect to see the final rule for Stage 2. That would give us a pretty specific, obviously very specific indication of what the approach to Stage 2 quality measures was.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, okay.

David Lansky – Pacific Business Group on Health – President & CEO

Kevin, anymore you want to say about where we are on the timeline and lifecycle?

Kevin Larsen – Office of the National Coordinator

Certainly, so as you all know there has been considerable investment on the part of CMS to develop e-Measures for use in the Meaningful Use Program as well as for use in the other programs and Patrice Holtz from CMS is on the line and she has been very involved with us, as well as our team at ONC, doing a lot of measure development.

So, we recently had a meeting between CMS and ONC, and our putting together our menu, our list of measures that are currently in the pipeline of development because this committee charged us, after Meaningful Use 1, with a series of measure development efforts that we were executing on, some of those measure development efforts actually span deliverables for both Meaningful Use 2 and Meaningful Use 3. So, not only are we currently building measures for Meaningful Use 2, we're building measures in anticipation of the Meaningful Use 3 rule.

So, part of the work plan here over the summer is to give to you guys on the Quality Measures Workgroup access to what is in the development queue so that you have a sense of where we're headed. We do still have some ability to change direction in some of those areas and so we want your early feedback as we continue to move down the development path.

We also have a number of analyses and perspectives that can give some real thoughtful input to this committee I think about what lessons we've learned from the development of e-Measures, harmonization of e-Measures, implementation of e-Measures. We have agreement from the CMS Division, called OCSQ which does a lot of the measure development for CMS, to share with this Workgroup the lessons that they've learned in this measure development and use in their programs.

We also have a couple of people that have been developing measures at the frontline who have done some real thoughtful analysis that we want to bring to this group, notably a group from the MITRE Corporation that had a contract to build measures using value sets across a number of measures, it has a lot of insights in that kind of oversight role that they play in measure development. So, those are some of the kinds of activity that we are planning to use to inform this committee and as you think about where you want to go with measures in the future.

As to timing, I guess I'll make a brief comment about timing. We continue to hear from the vendors and the public the desire, this was very clear in the comments of the NPRM, they would like the measure specifications with as much advance notice as possible because that allows them to have plenty of time to implement and build those measures and get them into their systems in time for any kind of a CMS incentive program. So, there is talk, and I think Paul has been part of this here at ONC to work to do whatever we can to accelerate our timeline to give maximum amount of time for appropriate testing and implementation for the measures use in our program.

David Lansky – Pacific Business Group on Health – President & CEO

Let me ask Jim Walker to make a comment, if you're willing, you know, some of this breaks down into we've got a sort of policy and strategy component of what is the valuable and appropriate contribution that quality measures in Meaningful Use can play to the larger drivers of improvement. And then secondly there is a fairly technical set of issues that certainly surfaced at our hearing in June around the architecture of value sets, standards sort of the component tool kit of e-Measures and on paper it makes sense to think of the Quality Workgroup on the Standards Committee as the place to do a lot of the work on the standards architecture, etcetera, and this group to do more of the work on the programmatic philosophy of quality measures, if you like, what's the value added contribution that this program can make to the larger effort of creating this capability.

But, Jim, where to you think your subcommittee is going to go with regard to the quality measures infrastructure build, for lack of a better word? I mean if they wanted to…the reason I'm caught on this is Kevin's comment about the vendor desire for early information on specifications. I am hoping we can move away from this model that says you need 18 months of advanced warning to put a new measure in the field, which comes back to this question of modifying the basic architecture and library of standards. So, rather than perpetuating the model that we're always going to have to be 18 months or 2 years ahead of the curve, I think we want to use this opportunity to improve the model. Jim, are you on? Can you make any comments about all that?

Jim Walker – Geisinger Health System – Chief Information Officer

Yeah, can you hear me okay.

David Lansky – Pacific Business Group on Health – President & CEO

Yes.

Jim Walker – Geisinger Health System – Chief Information Officer

Okay. So, you know, I think we're very glad that NLM has been contracted to manage the value sets, I think everyone believes that that is going to be something that quickly makes the creation of use for quality measures and their implementation in EHRs more consistent, easier, more useful. The second thing is that ONC apparently has gotten legal agreement, legal dispensation for this committee and the Standards Committee Quality Measure Workgroup to communicate directly and work back and forth directly so we don't have to play telephone with ONC and HHS, and all, and that's got to help.

The next thing is, I agree with David about, you know, trying to create, and we're certainly, every opportunity we're given on the Standards Committee Workgroup, create an ecology where this doesn't take nearly so long. On the other hand, I would make a strong, I would urge us strongly right now it is still the reality that even for very robust care delivery organizations using industry best software the turn-around-time is 18 months is not too much and I would just from an engineering stand-point it's always the case that one's own, in this case, quality, this committee and the Quality Workgroup, you know, one's own issues are very impressive to one, and this is true of ONC and HHS also, and other people's needs are just inherently less present, less salient, and so I would really encourage us to say, by this date we're going to get this done and we're just going to present it to…we're just going to do it.

And certainly for the Standards Committee Workgroup I would commit us that you give us a month to turn it and we will turn our part of it and we will be bound, we'll be happy to be bound by a date certain to deliver what we have to deliver back to you. So, we'll try our best to help make this, make our end of this thing as rapid as we expect their end to be.

David Lansky – Pacific Business Group on Health – President & CEO

Thanks, those are really helpful comments. Let me open it up to other folks to comment on this sort of general timeline and strategy question, and the issues that Jim just raised.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David, this is Paul Tang, can I make a comment?

David Lansky – Pacific Business Group on Health – President & CEO

Sure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And I'm driving so I hope it's not too hard to hear, but a couple parts to the timeline or multiple parts to the timeline, one is the timeline to actually develop and test new measures. So, there is a finite amount of time that is required to go through the realm of process and the testing process. So, I think some of the parts you actually can't cut short, it's almost like the whole peer review of literature, there is a certain amount of time either to do the review embedding versus oh well why can't you just get it out when you're done with the trial and have it gone through everything. So, there is a certain amount of that time where you want to make sure that measures that are widely used and in the future get paid upon are good ones, because there's so many things that you don't think of a measure developer or as the first implementer that comes up during the testing. So, that's one of the things I don't know that we can or want to cut short.

The software development time is one of the areas where we do want to cut short, I think, right now as we all have acknowledged it's really hard coded into these systems and maybe, and I think you made this point, David, we want to move towards the software platform that allow us to quickly go to something where we can put these "plug ins" in and as the plug ins evolve, as the measure description and definitions evolve we can rapidly accommodate that. So, that's after the process of making sure you've developed a good measure and tested it.

The other piece that we talked about in the past is the ability for a local organization to configure where a specific data element should be pulled from in the EHR that fits their workload. Because a lot of the complaints we've heard was that hard wired definitions in the EHR system actually ended up hard wiring workflow that all the healthcare organizations had to comply with and that was an unintended consequence.

So, I think there's multiple segments of the timeline and we have to figure out which ones we really can move and which ones we can't move in terms of the process of the measures themselves. And maybe more people, and we're going to get an update at our September HITPC meeting that standards already had about the value set authority center at NLM, that's something I think all of us have been asking for now it is sort of coming into being and that will be a big help, that will help the vendors I think and also help that timeline.

David Lansky – Pacific Business Group on Health – President & CEO

Thanks, Paul.

Eva Powell – National Partnership for Women & Families

David, this is Eva, kind of spring boarding but it's off of Paul's comments and the previous comments. I agree with Paul that the testing process is one that shouldn't be cut short but I think it is one that we can have impact on and this goes back to this notion of incorporating some sort of testing component to Meaningful Use in order to leverage all the work that we know is already going on out there and thankfully, as Kevin said earlier, ONC is leveraging that work through their work with MITRE, but there's more than just what MITRE is doing, and if providers who are tweaking the measures and creating their own can be leveraged and we can learn from that, then that is real world testing and we should leverage that. I mean, right now that real world testing is really going to waste except for in the particular institution that's doing the work.

And I think Health IT is very much a part of that and that this is a critical component of the so called learning healthcare system which remains a very ephemeral and nebulous concept right now, but this is a key piece that I think Meaningful Use can really help us move toward and I'd like to see us take some steps in that direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Can I piggyback on that, David?

David Lansky – Pacific Business Group on Health – President & CEO

Sure, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, I was going to add that point in so thank you Eva because I think you suggested this in one of our meetings. So, more specifically to what Eva was saying is, so let's say you have the six categories, you know, domains that this group have proposed and ONC has suggested is one of the options, pretend you, instead of all six, or you got a waiver if you submitted essentially a quality measure that your organization developed and used, and fill out some of the NQF submission form, and the reason for doing that is that it states your background and the…etcetera, so it's not the full application, but tell us your experience, in a sense it's sharing but in a very disciplined way. And as part of the incentive or the encouragement to do that, you know, you would get a bye on one of the six categories for example…because that's a concrete way that potentially even in Meaningful Use 2 we can encourage that kind of innovation and get…entire field.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah and that's very good, thanks Eva for bringing that back. We talked about this some months ago and thinking about whether Stage 3 could be a place that we do up a learning community model and find some way along the lines of what Paul just described to give credit for people who pick up some measures or advance some measures that could be really valuable additions to the field but haven't already been fully through the pipeline process.

It strikes me so far that in our conversation there are at least four buckets of work that we want to think about, one is the pipeline of measure development and availability and what's used in the formal program that we adopt. The second is this architecture of standards, coding, implementation problem, the plug and play, this goal, versus the hard wiring.

The third is the criteria for measures inclusion such as what Eva and Paul just described and whether we want to create new flexibility or new models for that rather than having a check list of 125 measures and you just pick the ones that we've already identified.

And then finally, we haven't talked about much yet, but Paul just eluded to it, how we're doing on populating the grid of six domains that we recommended and the Tiger Team had teed up earlier, maybe that's part of the pipeline discussion earlier, but essentially the question is do we still want to focus everyone's attention on populating that grid.

And clearly those four topics, there may be solutions that cut across all four, which I think is where Eva was taking us as a somewhat elegant framework to populate the blank spaces on the grid by means of a learning community's contribution to those areas and then how do we couple that with the NQF process so that we bring those protomeasures into the mainstream so to speak and I know Eva had done some good work sketching out an approach to that a couple of months ago we may want to come back to.

So, those are at least four categories and all of them would be formed by what Kevin started us on, which is the current state of play on the CMS work the contractor's work, the pipeline development, lessons learned and so on.

Kevin Larsen – Office of the National Coordinator

David, this is Kevin, if I might add another category and that I would call something like suites of measures or measure alignment that some of the insights that we've been getting is that although there's a desire for that same measure concept to be used across different uses the measure itself when it's so highly specified doesn't necessarily meet the intention very well.

So, an example is if we take a measure design for a fee for service outpatient provider practice that may not be the exact same measure that works really well for a shared savings program in an accountable care organization that has access to claims data and a whole suite of case management tools. It doesn't mean that they can't share a lot of the same architecture and goal, and even fundamental concepts, but they may not actually be exactly the same measure.

David Lansky – Pacific Business Group on Health – President & CEO

That's really valuable and it strikes me that similar to where we once were with measure concepts and you can imagine maybe there's an intermediate level of specificity of a measure concept, a little more granular than it was in our last go around, which is operationalized differently for different programs in the way you just said, but at least communicates the same policy priority across the different program settings.

Kevin Larsen – Office of the National Coordinator

Yeah, so I think that as the more we dive into this the more it seems that we can say, you know, hypertension control with really specific evidence and the same blood pressure goal may have some nuance differences that are important enough to call it out as a suite of related measures for different programs.

David Lansky – Pacific Business Group on Health – President & CEO

I would think on the face of it, tell me if I'm wrong, that the outcome specification for such a measure is fairly consistent, but the process measure or the ability to capture the data in a consistent way might vary by setting and by program.

Kevin Larsen – Office of the National Coordinator

Yeah, I think there are a number of different ways that they can have some either subtle or significant differences and that's the kind of thing we can help articulate for the group, but for example, as we look to VA measures, which are fantastic and we like them, they have claims data so they can get medication fill rates routinely. And any time that we do feasibility testing of a measure for the Meaningful Use Program for eligible providers that need medication fill data the current state of the interoperability is that is not feasible for eligible providers.

So, in the future we might be able to use that kind of information as soon as we have a much higher rate of interoperability and access to the pharmacy fill information, but right now those kinds of ACO measures don't move very well to ineligible provider fee for service settings. They can be refigured and we can move to the prescribed medication instead of the dispense medication but then it's got some subtle differences in how the measure actually works.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Kevin's comment brings up another comment if you have time, David?

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, go ahead, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, it's a really important comment as far as the difference between an ACO and their access for example to claims data versus an EP, but interestingly there's a new phenomenon that's going out in the pharmacy world where you have automatic fill which is a convenience for the patient in one way but it turns out to then potentially with and unintended consequence destroy the value of a refill data.

So, in other words, you keep piling up the envelope, the mail keeps coming, you know, usually it's sent to you by mail, so that keeps coming even though you haven't caught up or you haven't taken all your medicine. Do you see what I'm saying?

So, it's one of those things that the world has changed the meaning of certain information, we'll have to sort of adjust to that, but it's one of those unintended consequences we sort of have to account for when we design the measures.

Kevin Larsen – Office of the National Coordinator

Yeah, there are a range of these, we've had some measures that were initially designed for a survey of patients or essentially a patient reported outcome and we want to use them in again an eligible provider program, and so we can do that but it has some definite impact on how the measure performs and how the measure is specified.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It goes back into this testing, the importance of testing, those things that you didn't anticipate.

Kevin Larsen – Office of the National Coordinator

Yeah and I think…so I…the way that I think of this issue is in two related ways, one is kind of a fit to program and another way is as a suite of related measures. And we've talked before quite a bit about a suite of related measures and how that can be maybe a helpful thought, and so you can imagine a suite of related measures with nearly exactly the same description, but the subtle differences based on the program they go into or a suite of related measures that are meant to be used together by one program for different purposes, maybe one is for the purpose of the federal incentive and the others are just process measures to give visibility for quality improvement for example.

David Lansky – Pacific Business Group on Health – President & CEO

All right, so we've got now five or so concepts or categories we'd like to be able to make recommendations in at the moment. Kevin, let's just for a second detour and talk about the…timeline. I think in the material we sent out this morning at the end there was a very high level sketch of a sequence that ONC thinks will work and as I going backward the draft transmittal letter April 2013, I take it that would be when this Workgroup is ready. Is that the transmittal letter from the Policy Committee to ONC or is it from us to the Policy Committee?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's the Policy Committee to ONC so we were…our new target, given what the advance warning that ONC wants the program in, is to have a transmittal letter being sent in May of 2013. So, that's why it wouldn't be approved in the April 2013 meeting.

David Lansky – Pacific Business Group on Health – President & CEO

So, working backwards from there we would want the Policy Committee to have made…given us input and commented on the quality measures recommendations well in advance of that in order for the Policy Committee to feel comfortable with its own views by April.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, let me add one more salient milestone, the plan is to have an RFC go out for comment on November 6th…is to work backwards and give people Christmas off and for that of course it's an important opportunity to hear from the broad public, so we'll want to…hopefully we can take advantage of that with all the Workgroup including the…

David Lansky – Pacific Business Group on Health – President & CEO

So, Paul, as you've conceptualized that and Kevin, our contribution to a request for comment would be either a proposed approach or a set of questions for public input, right?

Kevin Larsen – Office of the National Coordinator

Yeah, ideally I think a proposed approach with some questions.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, all right, so if we wanted to be ready to get that done by November 6th and had that then supported by the full Policy Committee, working back from that, probably by the beginning of October, we want to have a pretty well developed approach and identified set of unresolved issues. Do you think October 1st is a good target for that, Kevin?

Kevin Larsen – Office of the National Coordinator

Yeah, I think that makes a lot of sense to me.

David Lansky – Pacific Business Group on Health – President & CEO

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

But, just to let you know on the Meaningful Use Workgroup that's why we're working backwards from August 1st for the first preliminary look at the full Policy Committee level, then we do our revisions based on that to come to your August, your October 1st approval for the RFC draft.

David Lansky – Pacific Business Group on Health – President & CEO

Right. So, we won't have the benefit of the final rule for Stage 2 prior to our needing to prepare most of this approach and etcetera for the request for comments. So, we'll just have to do the best we can in the absence of that clarity. So, then working…so let's say we have now we want a proposed approached to Stage 3 quality measures by October 1st and we have from today's discussion and previous, we've got roughly five topics or areas we want to try to be able to answer clearly.

Kevin proposed, I think, very wisely that we use then next meeting to get as much update as we can from the work in the field and the CMS activity and others so that while we can't have specific information about the Stage 2 decisions, we can have a pretty good approximation of the key lessons that would guide our further work, and then of course we can also hear about MITRE's work and the value sets from NLM and so on. So, that would be our next meeting if we can align all the people to give us that information and that is probably a pretty deep dive into a number of topics.

And I think also, at that point, Kevin we could bring to this group a more formal summary of what came back from the hearing in June. Jim, in terms of the Standards Committee's Workgroup what do you think, given, how are you looking at the request for comment issue and Paul is there participation from the Standards Committee workflow in the November 6th request for comment or is it really being driven by the Policy Committee? Let me see if that question made sense.

Jim Walker – Geisinger Health System – Chief Information Officer

Is that a question to Paul?

David Lansky – Pacific Business Group on Health – President & CEO

Or, Jim, whoever, whether you all have already discussed whether the issues around the standards and the technical approach to the quality measures would be reflected in the November request for comment or is that strictly sort of the Meaningful Use policy issues and not the standards and certification issues?

Jim Walker – Geisinger Health System – Chief Information Officer

I don't believe that's come to the Standards Committee Workgroup as an option. I would be happy to discuss it and try to achieve it if it's, you know, if there is a task we need to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it was originally, I mean it's an RFC from the Policy Committee to the extent that is helpful. I think we would love to have anything that the Standards Committee would want to include in that. So, maybe the date is driven sort of by the timeline that ONC and CMS would like to meet. But, I'm happy to incorporate some things that the HIT Standards Committee would like to include.

David Lansky – Pacific Business Group on Health – President & CEO

Okay.

Kevin Larsen – Office of the National Coordinator

This is Kevin, there are also some standards type questions that are starting to arise as we do the work with NLM that may not actually need to come to this committee, they may be the sort of things that we can handle, but they are things like versioning and how to handle versioning of vocabularies and what constitutes a sort of substantive change in a vocabulary that actually impacts a measure, and how does that all inform kind of semantic interoperability of the data that is needed to make measures.

So, if one organization is using ICD-10 and the organization next door is using ICD-9 and now you want to compile a quality measure out of the two of those, does the result necessarily now have a different result than it would have had if both had been using ICD-10? So, there are a number of those kinds of choices of the already agreed upon standards that are impacting the way we think about measures.

David Lansky – Pacific Business Group on Health – President & CEO

Well, one of the things I'm hoping we could do is try to keep a little bit of separation between all those issues which are extremely important from an implementation side and obviously the rulemaking, and the standards and certification requirements, and the directional approach we want to take at a policy level with the quality measures. And then the bridges piece is this architecture of the plug and play question and the issue that the proposal that Eva made of whether we use the policy framework as a place to do technical development under the sponsorship of individual professionals and facilities.

So, I think maybe the best way to tackle those questions of overall strategy will be to hear the input that we just talked about for the July 30th meeting and from that come to a set of conclusions about the overall strategy and approach and whether we want to modify the current as best we know at the Stage 2 approach, which is essentially picking from this long menu and move towards something that at least allows for participating organizations to submit measures that meet some criteria we can identify.

Kevin Larsen – Office of the National Coordinator

Yeah, so like I said, I didn't know that this would necessarily reach the level of the Workgroup, but that's one of the kinds of lessons learned that I think we should focus on. Another thing that we've talked about possibly being on the table that would bridge both the Standards and the Policy Committee might be the endorsement of certain tools to be used as a standard for use in multiple measures.

So, just as an example, the PROMIS tool, this patient reported functional status tool, you could imagine that, that gets endorsed as maybe a Meaningful Use objective and we built a standard around it and then we ask that a wide number of measures leverage that same tool or even ask that organizations across the country as they think about building their own measures use that as one of their standard-based framework. So, that's another kind of discussion this group could have or maybe that's not the kind of thing for this committee.

David Lansky – Pacific Business Group on Health – President & CEO

Good, I think it is; I think it makes sense that that would be a candidate resource that measure developers and this program as a whole could consistently leverage. Let's see, so apart from what we've just summarized in the way of…given we're going to be on a fast track timeline, we won't have a lot of time for more input or research, or hearings then today is probably the day to make a decision about what external resources we want to bring to the process.

So, what we've said so far is we will get input from the federal agencies and some of the independent groups like MAP and NQF that have been working in this space to give us their best advice on what has been learned to date and how we can take advantage of it.

We will learn from some of the technical inputs like the value set work and MITRE's work, and the measure developers that are out there on what they can share with us. We will capture that input as best we can in the next few weeks and digest it, and apply it to a set of recommendations at least or an approach, or a skeleton of an approach in the five or so areas that we've talked about today and we'll try to formalize that before the next meeting what those areas are and what the key issues to resolve are.

We'll stay in close sync with the Standards Committee and Subcommittee work and so that would give us August and September to drill down into those five topics and come up with a proposed approach for Stage 3. Given that general approach any other sources of input or direction people want to make sure we capture before we launch into actually starting a draft of the approach?

Tripp Bradd – Skyline Family Practice, VA

This is Tripp; Kevin and anybody else, I know you guys have been working on that open architecture or platform which seems to be and keeps coming back to the key to making this all come together. What's up with that so far?

Kevin Larsen – Office of the National Coordinator

So, this is Kevin, again, the open architecture we have a number of projects under way that are focusing on some components of that including some work to build an API for clinical decision support for example. The current landscape of quality measures, just in my opinion, is so variable that it's hard to imagine how they all fit into that same work flow and therefore how they all fit into the same set of tools.

If the measures were not so workflow dependent it might be possible to build a…or if they were more workflow aligned, you could imagine them being built into a really similar set of architecture. But in the current work that we have, we have, the vendors have created a different workflow for each and every measure and that's one of their core challenges is this kind of usability/flexible platform trade-off.

So, how exactly to ensure that not just the vendors platform is flexible but how do the measures that we build actually are built to best be able to leverage that kind of a platform is a question in my mind. So, one of the things that we're doing actually is our Vendor Tiger Team really actively engaging the vendors in how we can think about this and how we can think about how we build the measures.

We're also looking at compiling a number of workflow documents around the clinical quality measures to see which measures are kind of most amenable to this flexibility and ease of implementation, and which are the most challenging to implement because of their real uniqueness as a measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, Kevin, this is Paul, can I ask, has the group considered…instead of being…instead of trying to standardize the workflow across America in all kinds of practices, the alternative of coming up with a very specific definition let's say of the data element and allowing the healthcare organizations to decide where to grab that from in the EHR. So, where is it in their workflow that works best for them do they store this information about blood pressure or smoking, or whatever.

Kevin Larsen – Office of the National Coordinator

I think that is certainly quite possible. We live in a very heterogeneous world of EHR implementation right now and the early NLM analysis is we have 200,000 individual codes in our measures for the Meaningful Use 2 Program. And so, part of this is that the measures that we currently have are quite variable one to the next and I think that would be…I think that's a possibility to do around a smaller subset of measures than the kind of measures that people have for the wide range of priorities of measurement that we currently focus on.

So, there has been a lot of work in that realm, that's really what the QDM was about, but so far the measurement world is really in this innovation stage trying to figure out how to take things like the QDM and really let that be the driving force for the measure development as opposed to kind of anything that anyone can think up.

Jim Walker – Geisinger Health System – Chief Information Officer

This is Jim; I'd just like to…I don't know, I think re-enforce that, I mean, what we are talking about moving from the current state to a more standardized multipurpose, flexible state, which we have to get to, is incredibly complex and as far as I know there is no single implementation of this introduction anywhere. And so from a standards perspective what we would say on the Standards Committee almost certainly is this is great but its way too early to be made in any way required, what it needs is to be flushed out, tested, piloted and found to be mature enough that it would be appropriate to make it a standard.

And just quickly, second sort of strategic thing that I think we want to take seriously is there is increasing comment about the importance of quality measures being evidence-based, and for me evidence-based doesn't mean just randomized controlled trial, it means, you know, evidence-based, but clearly based on some evidence and that evidence being made explicit.

David, I sent you the paper and I didn't have everyone's e-mail address and I didn't know if you'd want to…but anyway one of the major journals had just a two throttling article demonstrating, to my satisfaction anyway, that our differential approaches to prophylaxis of VTE and prophylaxis of GI bleeding are based on everything in the world except the evidence, which is very good in both cases. And there are stakeholders who, well you can read it a number of different ways, but who are starting to criticize quality measures on the basis that they are not evidence-based.

And so I think we really need to, you know, think carefully and if we don't do it justify why we're not focusing on quality measures for which there is evidence of large population benefit and so on as opposed to taking a more…an approach that's harder to characterize in any charitable or systematic way.

P. Jonathan White – Agency for Healthcare Research & Quality (AHRQ)

Hey, Jim, this is Jon White, for those of you on the phone who don't get the benefit of Jim's e-mails over the weekend, I've had the pleasure of taking a peek at the article that you mentioned and I have two kinds of lines of thought that I want to throw out there. The first is that, I think the point is well taken about the level of evidence behind a given set of, you know, any given quality measure. We've had similar discussions in the clinical guideline development community, which, you know, as you all can appreciate, is pretty close, you know, runs in parallels, and, you know, some of the discussions have been along the lines of, you know, using the grade system to describe the level of evidence that goes along with it, and I think that that's a larger quality measurement issue to be discussed, but certainly very relevant to what we do here.

The flip side of that coin is, you know, look maybe the evidence is not great behind it, but, you know, shouldn't we be measuring something and this is where the Eva and the David Lansky's of the world, you know, pipe up, and, you know, the Eva's and the David's and folks like that need to be able to say, I understand what goes along with asking for these measures and the process is that that subsequently describes, and I think that there has been rich conversation that we had there, you know, because, you know, the law of unintended consequences always obdurates if that's what the test is and then people are going to…the test. So, those are no conclusions, but just lines of thought that I think there are further discussions.

David Lansky – Pacific Business Group on Health – President & CEO

This is David again, I think I appreciate, Jim you sending the material around raising the issue, and to me, and this goes to I think Jon's point, one of the implications is whether…this goes back to the big question of what's our role within the Meaningful Use HITECH Program in quality measures and I think we've said several times we think we want to create a capability in the EHR enabled environment to officially report quality measures to external parties and to permit the capability to use that information for quality improvement internally and do what we can to make sure that tools that this program stimulates have those capabilities, but we are not the policy makers around quality measurement and so what CMS uses for ACO reporting or other, you know, other requirements isn't our job.

So, we're not the ones proposing quality measures for general use, for payment or other purposes, we're the ones trying to use exemplars and tools and standards to build a capability which is flexible and supports many other more important organizations purposes. So, how best to do that is really the question I think we have to keep coming back to. So, I would…

Jim Walker – Geisinger Health System – Chief Information Officer

This is Jim, I agree.

David Lansky – Pacific Business Group on Health – President & CEO

Okay.

Jim Walker – Geisinger Health System – Chief Information Officer

I think that approach is appropriate, all I'm saying is that within whatever the setting is there are still better and worse evidence measures that would be available to create those exemplars from and they have greater and lesser predictable impacts on population health and, you know, granted the other constraints…if it were the truth and we can say, you know, we created exemplars across a range of sort of needs or functions, but within each of those these are the criteria and they still represent something that is, you know, the ones that would have the most impact partly because that…most to really work out the soonest.

David Lansky – Pacific Business Group on Health – President & CEO

Let me add one other kind of high level notion that Kevin has mentioned which is whether…I'm hearing from this whole discussion very pragmatically and I appreciate Jim's emphasis on what's realistic and feasible in the available timeframe of this entire Stage 3 cycle, you know, should we lower our gaze a little bit and say, all right the framework for Stage 2, whatever, or if it's finally resolved, is basically the framework period and our job is just to make some refinements, encourage greater adoption of some of the capabilities, fill in some of the holes in the grid and call it good, and that's our work for Stages 1 through 3 versus pushing on some of the things we've talked about today like the adaptive architecture and the integration of PROMIS or other claims data and interoperability and so on and so forth.

So, essentially how ambitious given the realism of the timeframe and the industry readiness and the competing priorities that everybody has, we probably need to come to a high level agreement about that very soon in the next 2-4 weeks because if we say let's just fill in some gaps and lower our gaze and basically stabilize the national program around Stage 2 with a little bit of enhancement that's a different approach than grappling with some of these very difficult directional issues that we've talked about in the last 20 minutes. So, perhaps we can use the input that we capture at our next meeting to do some core setting at that very high level. Because I could imagine two fairly different types of recommendations by October 1st depending upon which way we decide to go.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

David, its Paul; to respond to your question, I think we need to move closer to your second approach because we need to push the field. I don't believe we have the tools, so either we, my organization or the community has the tools needed to go even the next 5 years in the kinds of care delivery models that we would use. I think we have to push the field to do better. Now, I don't think…in some areas I don't think it's a big reach, so I'm not sure I agree with what Jim said in terms of how far it is, let me give you an example, probably I didn't give a specific example, so maybe my suggestion may not have been understood.

So, as an example of how a system can be more flexible in interrupting a definition, let's say smoking cessation, it's easy to define what the quality measure developer wants to know and the question could be as simple as saying "is this person currently smoking" and the way you would…the flexibility I'd ask for in the EHR is to say, as a local organization where do you store the fact that a person is or is not smoking now and one group might put it in let's say social history, another group might say, well this is so important I want to put it in the problem list and I can use the tools in the EHR to pull up decision support.

Both of those should be okay and it easily answers the question is this person currently smoking and then the consequences would you like to help them to stop. And right now it is hard wired in the system to be in one or the other place to spike positive entire organization changes. So that flexibility of saying, okay here's the measure…here's the data element definition, is the person smoking, and I will tell you where we as an organization store it, that's the flexibility that would completely change the feasibility and the use of that particular measure. I don't think that's at all a far stretch, certainly by 2016 if not even 2014.

Kevin Larsen – Office of the National Coordinator

And this is Kevin; I think that your two ideas are not mutually exclusive, so I really like to think about this in the sort of lean framework, which is that the more you standardize and the more you use standardized tools the faster and more efficient the whole system becomes. And, so I think driving towards a set of standardized requirements to be used over and over again in each measure helps vendors to be able to build a flexible platform, but if we throw them completely different requirements for each and every measure that each one has to be a custom creation that doesn't leverage anything from the one before to the one after it, and every time a measure comes its again completely custom, that never lets the vendors catch their breath and build any kind of a flexible platform.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So…

Kevin Larsen – Office of the National Coordinator

So, I don't think the two are related.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I probably still didn't…so the vendor doesn't have to do anything but give us the tool that says okay here's the data element definition where would you like to pull that from? So, the vendor doesn't even have to know, they just give us the tool, they don't have to know what each person and each organization does. Do you see what I'm saying? So, there's actually no coding for the vendor except for having the ability to change where I've pulled this data element from.

Kevin Larsen – Office of the National Coordinator

Yeah, no, no, I'm with you Paul and I am on the same page, but what I'm saying is that currently the QDM was the first try at doing that kind of here at the data elements we need you to reliably pull and we learned a lot from doing the QDM, but it hasn't yet functioned in that way we want. So, I think continuing to move down that, here are the data elements that are going to be used over and over again in measures, build them, map them, use them, and then really building the measures around those requirements will help everybody a lot.

Jim Walker – Geisinger Health System – Chief Information Officer

This is Jim, do we have an industry stand on how feasible just what Paul is talking about and Kevin is talking about, but just what Paul's talking about, would be for HIT developers?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, actually it does exit, I mean, today and all this would require really is a change in the policy as far as "certification." So, as you know, almost every EHR nowadays, because it's part of Meaningful Use, can create a report of patients with "x" so you can…so the systems must be able to create a report of people…who smoke. Now in the process you're deciding where do you ascertain whether an individual smokes and you decide it, so that capability is already present in the EHRs, we need to make that okay to report a quality measure, as long as you can defend it in an audit to say, here is where I ascertained whether an individual smokes or not. Do you see what I'm saying? I hope that I'm getting a little bit better at articulating it.

Kevin Larsen – Office of the National Coordinator

Yeah and this is where we get to this idea of things like the PROMIS tool also, so a tool like PROMIS which is a standardized tool for measuring a patient's functional status is a different approach than what happens now for example as we look at measures of pediatric developmental assessment where there are maybe 15 different tools that could be used and we haven't specified which ones we've allowed for any of the 15 and that creates this inherent lack of flexibility because now there are too many and the industry can't really respond and it's hard to make those interoperable, it's hard to move one score from one place to the next.

Jim Walker – Geisinger Health System – Chief Information Officer

So, this is Jim, I mean, obviously if we can do things like identify the PROMIS as the standard way to capture and report "x" or relax requirements about where in an EHR the datum comes from that's all to the good, I just, I think we would be very smart to spec these things right now or in a week agree on them and then run them past HIT developers and HIT implementers for a reality check. You know, my team is always laughing at me because I create these narratives about what could happen based on what already exist and they come back and say, yeah and that would be 400 person hours and that's just at our location.

So, I think we have the capability to do a rapid reality check and if it's as simple as those two things, you know, then that would be great. I guess my concern would be despite the fact that PROMIS, as I understand it, is beautifully evidence-based and well tested, and probably makes sense as the standard, if vendors have implemented some other standard, God help them, and have to switch it out that may not be as simple as it sounds to us. So, I think we just ought to do the reality check fast so that we know for sure what we're talking about.

Kevin Larsen – Office of the National Coordinator

So, this is Kevin again, we do have the Vendor Tiger Team which is a subcommittee of this group, they are very engaged and willing to do this and so we can cue up any number of questions for them and they will give us really thoughtful sophisticated answers.

Jim Walker – Geisinger Health System – Chief Information Officer

Great, then I think we need to get them the questions. You know, again, I think if we don't set ourselves a deadline, the same kind of deadline we're going to be setting for vendors and implementers in whatever May or whatever it is, we won't get it done as fast as if we said, okay we're going to give them the first three questions within two weeks.

David Lansky – Pacific Business Group on Health – President & CEO

Well, let's see if we can summarize where we're at. We have a call, we have a schedule now, we have a call in two weeks and I think on that call we'll have presentations and hopefully some written material from several of the colleagues we have in various arms of this enterprise. I think we'll try…we'll work with the staff to develop a pretty tightly framed structure for these discussions we've just been having to begin to fill in an approach, a recommendation, and what I teed up a minute ago and Paul and Jim have amplified on whether there are two paths or something in the middle between a fairly conservative stay the course populate the grid approach versus the more ambitious how do we really build a robust long-term platform and then in the middle is there something that would be a hybrid which is adaptive to create more flexibility, less cost, less burden within essentially…

Jim Walker – Geisinger Health System – Chief Information Officer

Let me propose a really ambitious goal, David, sorry, this is Jim; the really ambitious goal would be to move as far as we can forward without making a mess.

David Lansky – Pacific Business Group on Health – President & CEO

That sounds pretty good; that will be a worthy ambition and even clean up some of the mess we have now.

Jim Walker – Geisinger Health System – Chief Information Officer

Right.

David Lansky – Pacific Business Group on Health – President & CEO

So, let me see if people have other suggestions that we can take in as we chart the work for the next couple of month and especially the next couple of weeks so that the next call we bring to you a pretty tight framework within which to operate.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp; I'm hoping that Kevin, that we can deliver some of the documents perhaps on the 27th as a goal as opposed to 4 minutes before the meeting.

Kevin Larsen – Office of the National Coordinator

Yeah, we apologize for that, we will get things out to you earlier, a number of things that we have for that meeting are already actually cued up and prepared, so that's our fault and we'll get something out to much sooner.

Tripp Bradd – Skyline Family Practice, VA

Oh, no problem, it's just, I think the meetings go faster if people have time to ruminate about it before the actual meeting.

Kevin Larsen – Office of the National Coordinator

Absolutely.

David Lansky – Pacific Business Group on Health – President & CEO

So, actually, I appreciate that Tripp; maybe let's see if we can push for the 26th, Kevin, so that would give people at least 1 or 2 working days to look things over.

Kevin Larsen – Office of the National Coordinator

Yes, we will do it.

David Lansky – Pacific Business Group on Health – President & CEO

Great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And…

Jim Walker – Geisinger Health System – Chief Information Officer

Other request in terms of process, if you could identify the four critical questions that we want to try to come to an answer so that we can sort of focus our reading that would be very helpful.

David Lansky – Pacific Business Group on Health – President & CEO

Very good, I think let's have a framework and some discussion questions on whichever topics we want to address specifically at the next meeting and at each of the subsequent meetings as well. Paul, were you trying to get in too?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I was just adding a note of optimism of what's possible. It's raining in California in July whatever it is 17th that's against the law, so some things are possible that you didn't think were.

David Lansky – Pacific Business Group on Health – President & CEO

Thank you, Paul, that's very heartening as I look out at the rain, that's good. Okay, any other last suggestions on how to make sure we get the most out of the next meeting and subsequent meetings toward our goal? All right, well hearing none, I really appreciate everybody taking the time today to do some good core settings and we will get materials out by Thursday the 26th and we will start into the meaty work of this on the 30th. All right?

MacKenzie Robertson – Office of the National Coordinator

Are we ready for public comment, David?

David Lansky – Pacific Business Group on Health – President & CEO

Yes, thanks, MacKenzie, yes.

MacKenzie Robertson – Office of the National Coordinator

Great, operator can you please open the line for public comment?

Public Comment

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via you computer speakers please dial 877-705-2976 and press *1 or if you're listening via you telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

David Lansky – Pacific Business Group on Health – President & CEO

All right, thank you MacKenzie and thanks everyone for your time today, we will release a few minutes to you for the day and talk to you again in a couple of weeks.

Kevin Larsen – Office of the National Coordinator

Thank you much.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David.